Premier Rescue Ambulance Services Limited

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Premier Rescue Ambulance Service Limited is operated by Premier Rescue Ambulance Service Limited. They provide a patient transport service to people living in Devon and Somerset and the surrounding areas. If required, the service reaches further out into the south west to provide patient transport services. The service provides non-emergency ambulance transport for people with mental health conditions, most of who are detained under the Mental Health Act 1983. The service also provides transport for non-detained patients, for example patients who are voluntarily going into hospital for referral or treatment.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 February 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was patient transport.

We rated it as **Requires improvement** overall.

- Managers had not trained any staff to level four in safeguarding to support and advise staff.
- Limited auditing of the service did not provide assurance of safety on an ongoing basis.
- Safety incidents were not monitored and there were no recorded actions and learning
- There were no governance processes to monitor service performance or make any changes for improvement despite tools being in place.
- Patient records did not contain information about risks and how they minimised these or any details about medical condition.
- Managers had no records to demonstrate staff were competent in meeting the needs of patients.
- A system for supervision and appraisals of staff had not been fully developed and implemented.
- The service had a criteria for patients they could meet the needs of but this was not documented.
- Managers did not use their information systems to monitor the quality of the service. Audits had not been devised to provide assurance of safety on an ongoing basis. There were gaps in the process and records of recruitment of new employees

We found good practice in relation to patient transport:

- Infection control procedures had been reviewed and updated. A clinical waste contract had been implemented.
- The service had enough staff to care for patients and keep them safe.
- Staff had training in key skills and understood how to protect patients from abuse.
- Staff worked well together with other agencies for the benefit of patients.
- The provider planned their service to meet the needs of local people and took account of patients' individual needs.
- The service operated 24 hours, seven days a week to meet the needs of patients who used their service.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected patient transport services. Details are at the end of the report.

Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires improvement 	Patient transport services was the provider's only activity. They provided services for a local mental health NHS trust and other providers where they transported patients who were detained under the Mental Health Act and other patients with mental health illnesses. The service was for adults.

Summary of findings

Contents

Requires improvement

Premier Rescue Ambulance Service Limited

Services we looked at
Patient transport services.

Summary of this inspection

Background to Premier Rescue Ambulance Services Limited

Premier Rescue Ambulance Service Limited is operated by Premier Rescue Ambulance Service Limited and opened in 2014.The service provides non-emergency ambulance transport for adults with mental health conditions to people living in Devon, Somerset and the surrounding areas. If required, the service reaches further out into the south west to provide patient transport services. The service is not provided to children or young people under the age of 18.

Premier Rescue Ambulance Service Limited is registered to provide the regulated activity Transport services, triage and medical advice provided remotely.

The service has had a registered manager in post since 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Information about Premier Rescue Ambulance Services Limited

Premier Rescue Ambulance Service Ltd provides non-emergency transport for people with mental health conditions living in Devon, Somerset and the surrounding areas. If required, the service reaches further out into the south west to provide patient transport services.

The provider had access to two vehicles for transporting patients. These were both people carriers which enabled patients space and the support of additional staff.

The provider had a Service Level Agreement with a local mental health NHS trust. They provide transport on a planned and adhoc 'as and when basis' for them. Other work was acquired from private individuals requiring informal transport for referrals or admissions and secure care facilities for other trusts/providers.

The service is registered to provide the following regulated activities:

Patient transport services and triage and medical advice provided remotely.

During the inspection, we visited the office in Taunton. We spoke with five staff including; patient transport drivers/ care assistants and management. During our inspection, we reviewed 30 sets of patient records. After our inspection we spoke with a commissioner of their services and mental health professional who had access to the service.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, in April 2018. At that inspection the service was not rated, and we found some areas of good practice and areas where improvements were needed. We issued two requirement notices, one in relation to infection control and the other to provide supervision and appraisals for staff. These were followed up at this inspection.

Activity between January 2019 and December 2019

- There were 901 patient transport journeys undertaken.

Twenty-six care staff/transport drivers and two qualified nurses worked at the service. There was no accountable officer for controlled drugs (CDs) as the service did not use them.

Summary of this inspection

Track record on safety in the last 12 months

- No Never events
- Clinical incidents nine low harm, and one death.
- Restraint was used on two occasions
- Two complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Patient transport services

Safe	Requires improvement
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

The main service provided by this ambulance provider was patient transport services. The service provides non-emergency transport for patients with mental health illnesses. They can transfer patients who are detained under the Mental Health Act and other non-detained patients with mental health illnesses. The service primarily serves the communities of Devon and Somerset but also provides some transfers out of the county.

The service had two large people carrying vehicles for transporting patients. They were not able to transfer patients on stretchers or patients who were not mobile or used a wheelchair.

Summary of findings

We found the following issues that the service provider needs to improve:

- Managers had not trained any staff to level four in safeguarding to support and advise other staff.
- Patient records did not contain important information about risk, how to manage these and medical conditions.
- Safety incidents were not monitored and actions and learning not recorded.
- Managers did not monitor the effectiveness of the service and made sure staff were competent. Supervision and appraisals were not taking place to support and monitor staff.
- Managers did not use their information systems to monitor the quality of the service. Audits had not been devised to provide assurance of safety on an ongoing basis. There were gaps in the process and records of recruitment of new employees.

However, we found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risks well. Staff assessed risks to patients and acted on them.
- Staff provided good care and treatment. Staff worked well together with other agencies for the benefit of patients. Key services were available seven days a week.

Requires improvement

Patient transport services

- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers.
- The provider planned their service to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it.
- Staff felt respected, supported and valued and they were focused on the needs of patients receiving care.

Are patient transport services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

The service made sure staff had completed mandatory training in key skills. But all training was not recorded.

Staff who worked for this provider had zero-hour contracts which meant most of the staff worked for other health and social care providers. The service had a list of mandatory core training that had to be completed in house or staff had to provide evidence they had completed it at their other job roles. This included prevention and management of violence and aggression (PMVA), basic life support, Mental Capacity Act and first aid.

We reviewed three staff training records and saw a variety of training completed. The certificates came from a range of training services. These included basic life support, fire training, record keeping, equality and diversity, deprivation of liberty safeguards, Mental Capacity Act, first aid and infection control. There were also records of positive management of violence and aggression training (PMVA). A member of staff confirmed they had to bring in all training certificates which were in date to confirm training undertaken.

We were sent evidence of a training matrix which demonstrated all but one member of staff had completed the some of the listed training. However, this only covered Mental Capacity Act, Deprivation of Liberty safeguards, safeguarding and infection control. Senior staff were aware this needed to be updated to include all training provided to have a clear picture of which member of staff needed any update on training.

No target had been set on how many staff had to have completed mandatory training each year.

At our last inspection the management team were in the process of setting up electronic alerts when training was due. There was no evidence this had been put in place at this inspection.

Requires improvement

Patient transport services

The service had recently appointed a member of staff to provide training to meet the needs of the service and staff. This would include mandatory training. This member of staff was a trainer for prevention and management of violence and aggression (PMVA)training. They told us they had plans to provide this for all staff based on the needs of this service looking at de-escalation of situations to reduce the need for restraint.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it but not all staff were trained to the required level.

We looked at the training records for three staff. Two staff had certificates from external training services which confirmed they had completed safeguarding training level 2 for both adults and children. The certificates did not identify the content of the training. The member of the management team who had the responsibility for training all staff did not have any certificated proof that they had completed safeguarding training.

The registered manager was the dedicated safeguarding lead for the service to provide staff with advice or support. They had undertaken safeguarding training, but it was not clear on their training matrix what level this was. To enable them to provide advice and support to staff about safeguarding they should consider training to level 4 so they would have the skills and knowledge to support staff.

The registered manager told us they had not made any safeguarding referrals, but they were aware of the process to follow if staff reported any concerns to them. Staff had access to a safeguarding policy that detailed the actions staff needed to take if they needed to report any allegations of abuse.

Recruitment files were not fully completed to ensure patients were safe. There were areas of the application form and Disclosure and Barring Service checks (DBS) which had not been risk assessed and an action plan completed to ensure patient safety. This was because they had evidence of a criminal conviction on their DBS check and had areas to investigate on their application form. For example, breaks in their career history

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept vehicles visibly clean.

The service made sure vehicles were appropriately and safely cleaned and ready for use. The two vehicles were cleaned at the end of each shift by the staff on duty and weekly by the nominated individual. Each month an external cleaning company cleaned both vehicles internally and externally. Records were maintained of all cleaning.

Should cleaning be needed between patients staff carried personal protective equipment, vomit bowls, wet wipes and a clinical waste bag. However, the cleaning chemicals used were not suitable for cleaning bodily fluids. This was discussed with the managers who advised they would obtain other suitable cleaning solutions. They also said they never had to clean up bodily fluids to date. Should the vehicle require deep clean following a patient transfer, they crew would return to the base for the clean to take place. Hand Gel was available in each vehicle.

Staff told us that they did not have linen or blankets and should the discharging hospital provide them they were passed on with the patient.

Crews were made aware of specific infection and hygiene risks associated with individual patients prior to the transfer. But this was not always documented.

There was a verbal handover of any infection control issues from the manager who had taken the booking to the staff. All patients had a written travel record and any infection risks would be recorded there for staff to see. This was limited in content and there were no recorded assessments of infection control risk and no clear instructions for staff to follow. Staff could contact the office in daytime and out of hours to request advice and discuss any concerns

Staff wore a practical, washable uniform which was laundered at home. Managers did not provide any guidance to staff regarding minimum temperatures for washing for effective cleaning.

We reviewed three staff training records and saw that infection control training had been completed.

Environment and equipment

The use of the vehicles kept people safe. Staff had access to arrangements for disposal of clinical waste.

Requires improvement

Patient transport services

The office base was not used by patients. The office was located on an industrial estate and was secured at night. Should staff need to access the vehicles out of hours a pass code was used.

When staff returned to the base out of office hours, keys and notes were stored securely.

Public liability insurance was displayed in the office building.

We looked at both vehicles and saw they were appropriate for their use and records demonstrated they were suitably maintained. Full-service records were kept, and a service plan monitored to ensure any ongoing maintenance was completed. Staff could report any issues with the vehicles when they delivered the vehicles at the end of each shift or contact the provider while travelling.

The provider told us they had criteria for accepting patients (this was not recorded) and therefore would only take patients for transport if they were able to meet their needs for safe transport. The vehicles were only suitable for patients who were able to climb into and out of the vehicle independently.

Parent and baby transport was provided for the treatment of the parent. However, managers told us this was rare. In those cases, a child seat was provided by the parent and secured on the back seat. Seat belt locking devices were used to prevent patients releasing their seatbelt.

Records were maintained of each journey which included mileage and the driver. There were no daily records maintained which would show that basic safety checks were completed each shift for example checks of oil levels and tyre pressures. Each shift the fuel was replaced and recorded.

Each vehicle was insured, and records maintained of each drivers licence. The insurance company instigated an annual check of all drivers to ensure all traffic violations had been included in their records. Staff had a responsibility to report any traffic violations to the provider at the time of notification. This would enable the provider to monitor for any frequency and take the appropriate action.

Each vehicle carried details of a 24 hours a day, seven days a week, breakdown recovery service.

There were two drivers for longer journeys to ensure that drivers did not drive in excess of four hours or were able to swap to another driver to ensure safety.

At our last inspection we issued a requirement for the service to have a waste disposal system which included clinical waste. At this inspection we found a system had been implemented. An arrangement with an outside provider with a license to dispose of clinical waste had been agreed. As they had very little clinical waste this was on an as and when needed basis.

Assessing and responding to patient risk

Staff mostly minimised risks to patients, but risk assessments were not completed for each patient to demonstrate this. Staff identified and quickly acted upon patients at risk of deterioration.

The provider spoke about the patients they were confident to transport, these were low risk patients. There were no formalised documented exclusion criteria for staff to follow and no audit trail of decisions made.

A conveyance policy detailed how staff monitored patients during the transport and when to call for external assistance. For example, the Police if the patient was at risk of absconding during a planned stop if on a long journey, or an emergency ambulance.

We saw documented evidence that staff had responded to the deteriorating condition of a patient during a transfer and called for an emergency ambulance.

The policy for the use of restraint soft/handcuffs also provided staff with guidance on when to call for Police assistance or return to the original location if they were unable to manage the patients behaviour. This policy mentions the use of risk assessments to determine the risk, however, we did not see any risk assessments in the 30 patient records we reviewed.

No risk assessments were completed by the staff or management when a journey request was received or after as part of the assessment to demonstrate they could meet the patients transport needs safely.

We saw one record which identified the female patient was fearful of men. This was discussed with the ward but not recorded as a risk or how this was managed with male escort staff.

Requires improvement

Patient transport services

All staff were trained to use restraint if needed to protect themselves and the patient if their behaviour became too challenging or they were showing aggression and violence. There were no records of how de-escalation was managed. All incidents of restraint were recorded but not as incidents until recently and there was no audit or review of these restraint incidents. To make sure they were in line with best practice guidance. Staff carried securely a ligature release knife should that be needed and explained why that may be needed.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave all staff an induction.

The service had 28 staff, three of which were fulltime. All other staff worked on zero-hour contracts. This meant they only worked when they were needed. Most staff had other permanent work with other providers. Managers told us most staff had mental health experience. Two of the three managers were qualified mental health nurses who were able to support transfers if required.

The service had a system where staff let them know when they were available for work each day. As the work was mostly adhoc with some work pre planned they could only take on the adhoc transfers if staff were available.

All ambulance journeys were completed by a driver and two escort staff. There was also capacity for hospital staff to escort if agreed.

All staff were given a copy of the services staff handbook. This provided human resources information for staff and not policies or procedures. However, it referred to another provider. This was amended during our site visit.

All new staff had to undertake a set induction programme. We spoke with a new member of staff who confirmed this. We were shown one of the induction forms. However, the form was not signed to say the member of staff had completed the induction and when.

Records

Staff did not keep detailed records of all patients' care and treatment. Records staff had completed were stored securely and easily available to all staff providing care.

Booking staff took the initial patient details and contact number and passed this to the provider. A staff member was available 24 hours to receive calls and organise a transfer. The provider then contacted the requesting service to gather details of the patient and journey. A travel record was then completed and passed to the crew. Any risks associated with the journey were discussed with the crew but not formally recorded. We looked at 30 travel records and saw that they did not include any physical illness or any details of the patients mental health. There were no risk assessments and action plans completed and no recorded transfer of that information to the vehicle crew. This meant there was no audit trail of information communicated and there was a risk that information may be missed.

At a staff meeting in January 2020 there had been a recorded discussion about the need for relevant information about patients must be passed to the crews regarding medical conditions, behaviour patterns and other patient risks.

We saw that restraint was recorded as being used but there were no details on the travel record of what restraint was used and for how long. The provider assured us this was recorded as an incident. However, staff had only recently started to record this as an incident.

Medicines

The service was able to transfer patients medications safely.

The service did not stock any medicine in their vehicles or in their office location. Staff did not administer medicines during the journey. They were able to transport patients medicines safely during the transfer as these were stored away from the patient who was in the rear of the vehicle

The registered manager told us if the patient had been assessed by the referring hospital/location as able to self-medicate the staff would assist them to do this by handing them their medicines as it would be stored away from the patient. This information would be passed on at the booking of the journey and staff shown information on collecting the patient.

Requires improvement

Patient transport services

We saw an incident form where staff had recorded a patient needed to use their inhaler during one journey to help their breathing.

Incidents

The service did not always managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. But these were not recorded. When things went wrong, staff knew to apologise and give patients honest information and suitable support.

At our last inspection there was a limited understanding by managers of the formal definition and the legal implications of the duty of candour. The registered manager sent us a copy of their duty of candour policy which mentioned what they needed to do to meet their regulation. It also mentioned how staff needed to be open and honest with patients if anything went wrong. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'.

One incident had met the threshold for Duty of Candour, but this also involved other providers and they were leading on the investigation into the incident. This was the death of a patient during transfer. The managers had sent in their investigation to the other providers and were waiting for an outcome at the time of our inspection.

Staff were aware of the system to notify managers of any incidents. We saw records of incidents. There was no evidence these had been reviewed by managers and any action needed from these shared. Managers told us if any lessons needed to be shared with other staff this was done. However, there were no records to support this. We did see in one staff members supervision records a debrief of the incident mentioned above for those who were involved.

All use of restraint was now being recorded as an incident. There has been two incidents of restraint in the last 12 months. But these were not being audited to make sure the restraint used was not excessive and were in line with best practice guidance.

Are patient transport services effective?
(for example, treatment is effective)

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment mostly based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983

The provider had policies and procedures that staff followed in the course of their work. These included safeguarding adults, Mental Capacity Act and Deprivation of Liberty safeguards (DOLs) and whistle blowing. Some referred to national guidance used to devise these but not all. The policy for the use of soft/handcuffs did not reference the latest guidance. For example, the Department of Health guidance 'Positive and Safe' (2013) and National Institute for Health and Care Excellence guideline 'Violence and aggression: short-term management in mental health, health and community settings' published: 28 May 2015, Guideline 25. Managers told us they were in the process of reviewing some of their policies and procedures to include the latest best practice guidance. Not all policies had a review date included. Staff had access to policies and procedures in each vehicle.

Staff had received training on Mental Capacity Act and DOLs by the provider and some from their other employment. Managers told us most staff worked with patients in mental health settings so were aware of their specific needs. Staff were aware of what paperwork was needed when transferring patients who were detained under the Mental Health Act and these were given to the receiving location. Staff we spoke with confirmed this.

Nutrition and hydration

Staff ensured patients' food and drink requirements were met during a journey.

Patient transport services

Staff carried drinking water on board vehicles to give to patients when required. The service did not provide food for patients. When travelling long distances, the location from where they collected the patient would be asked to provide food based on the needs of the patients.

Response times/ Patient outcomes

The service mostly recorded but did not monitor, their response times so they could facilitate good outcomes for patients.

The provider had a Service Level Agreement (SLA) with a local mental health NHS Trust. As this work was adhoc or 'as and when required' there were no performance targets to meet. However, commissioners for the local mental health NHS trust told us once a transfer had been agreed the service had a two-hour time frame to get to the location. They said Premier Rescue Ambulance Service did not always meet this time frame.

All journeys were recorded as a time leaving the base, time to pick the patient and time of patient delivery. Records recorded mileage to include the journey back to the base. This information was also collected for planned journeys. As the service was so specific, these records were not used to facilitate development or changes in service.

The provider had installed vehicle tracking software on both vehicles. This enabled the managers to monitor locations and estimated times of arrival to patients and to check the journeys were on time and not delayed.

Managers told us they planned to start auditing this information as they wanted to start providing estimated times of arrival when collecting patients. This was because they wanted to help the location, they plan to collect the patient from in getting all their information and belongings ready.

Competent staff

The service did not make sure staff were competent for their roles. Managers had started to evaluate staff's work performance and held some supervision meetings with them to provide support and development.

The training matrix in use did not cover all topics of training therefore we were not assured staff had training in all areas pertinent for their roles, for example, prevention and management of violence and aggression (PMVA).

Two managers were qualified nurses and evidence of their registration with Nursing and Midwifery Council (NMC) was obtained.

Managers could accompany staff on their journeys to evaluate their competencies. This included observations of staff skills and adherence to protocols. To date we did not see any records to demonstrate this. The service not able to provide any records to demonstrate this.

At our last inspection we found there was no system to provide staff with ongoing supervision and appraisals. At this inspection we found minimal progress to achieving this. However, a new member of staff had been appointed to the management team and one of their responsibilities was to provide supervisions and appraisals. We did see records for two staff who had a supervision session, a group session for some staff and a debrief following an incident.

There was no evidence managers ensured all staff who drove vehicles were competent to do so. Following our last inspection, they said "we have implemented a driving assessment tool to confirm practical driving ability. The assessment aims to check physical and cognitive ability to drive our ambulance vehicles safely and comfortably and to offer advice on aids and adaptations that may assist driving". We did not see this tool or evidence of its use in the staff files we examined.

None of the vehicles required a C1 drivers' licence. The C1 driving licence allows people to drive vans up to 7.5 tonnes. A driving licence check was recorded for all staff and this was an ongoing, reoccurring process .

New staff participated in an induction period. The staff handbook stated this was 90-day timescale. At the end of this period, managers told us they signed off the induction checklist. We were shown one of these, but it had not been signed or dated to demonstrate completion or that the staff member was competent to do the role. A member of new staff confirmed they had an induction period.

The handbook mentioned the process the service would take if the member of staff did not meet their expectations. There were limited details about their process for disciplinary procedures.

A member of staff had been appointed to provide ongoing training for staff. They had evidence they were competent

Requires improvement

Patient transport services

to be a trainer. They told us they had plans to provide prevention and management of violence and aggression (PMVA) to all staff based on the needs of this service concentrating on de-escalation skills.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff and other services worked well together to deliver effective care and treatment to meet the needs of the patients they transferred. Care was delivered in a coordinated way when other services were involved. A mental health professional told us they often worked with the staff from this service and they all worked as a team to meet the needs of the patient.

Managers told us they spoke with the ward/unit staff responsible for handing over the patient to discuss the patient's immediate needs and any changes in their condition or behaviour. This was passed on to the crew but not recorded.

The managers told us they had met with representatives from the local Mental Health NHS trust and the feedback they had received was positive about the services they provided. We spoke with the commissioners from the local Mental Health trust who told us the whole staff from this service worked well with their staff. However, they did mention two concerns where they felt the staff from Premier Rescue Ambulance service were not professional in their role in front of the patient, other carers and staff from this and other organisations. This was reported to the registered manager who investigated immediately and took appropriate action

Some patients required an escort from the departing NHS location to their transfer location. Staff told us they were able to travel with them in the vehicle.

Staff had access to information about the patients prior to the transfer/journey. For example, if a patient had a do not resuscitate order, they would transfer the original copy with them to the receiving location.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment where able. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff had access to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLs) policy. The training matrix stated that staff were up to date with training for Mental Capacity Act and DOLs. We were told staff also had training in the prevention and management of violence and aggression.

Managers told us most staff had experience of working with or were still working with patients who had mental health conditions, so they understood consent, Mental Capacity Act and DOLs. Staff we spoke with confirmed this.

Staff understood that patients may or may not have the capacity to consent and understood the process to follow when transferring patients detained under a legal section process.

Managers explained the process used when transferring a patient with a 'Do not resuscitate order' documented and their responsibility in that process.

The registered manager told us they only transported adults. Children were transported if they were related to the detained patient they transferred. For example, if the parent had been detained and the child was being taken with them to a location like a specialist mother and baby unit.

Are patient transport services caring?

Not sufficient evidence to rate

We did not have enough information to rate caring**.**

We did not observe any transfers, so we were not able to speak with patients or their relatives/carers. Because of this we do not have enough information to rate this section.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Requires improvement

Patient transport services

The provider described the service as transporting vulnerable people safely, discreetly and respectfully.

Staff told us they involved patients in conversations and tried to reassure them. Staff told us they respected patients' individuality. Staff told us at interview the managers told them they had a list of expectations on how staff treated patients. This included maintaining their privacy and treating them with respect.

A mental health professional who worked with the staff told us they were kind, calm and patient.

Wherever possible, staff tried to respect patients' privacy and dignity. This was sometimes difficult due to their circumstances and required the staff to be flexible and responsive to the risk levels. Managers had purchased new vehicles, with darken glass to provide privacy for the patients transported in the vehicles.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff told us how they used de-escalation techniques to minimise the impact of distressing situations for patients. Staff told us how they showed empathy, for example by offering a hand to hold.

When patients were anxious and/or confused, staff told us they gave them reassurance.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Complementary letters had been received which detailed how staff had been kind and considerate and how this had been appreciated.

A mental health professional told us staff would often chat with relatives or carers prior to the transfer of a patient to help minimise their distress.

Staff told us how they only ever used restraint with caution and if necessary. Staff constantly evaluated how they could reduce the level of restraint used during the journey whilst keeping the patient safe. Staff involved patients in this process wherever possible.

Feedback from a mental health professional told us staff were always mindful of the relatives when they transferred patients. They said they always involved them when they were able.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as **requires improvement.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The main service was a patient transport service for patients with mental health conditions. They provided non-emergency transport for patients. They had a service level agreement for their services with a local mental health NHS trust. They received other work from other mental health providers.

All care staff/drivers had a zero-contract hour contract as their work was mostly based on adhoc or 'as and when needed' transfers. Commissioners from the local NHS trust told us they put out requests to the services who provide them with transport and those who respond with details on how they planned to meet the transfer request were offered the job. Managers told us once they received a request for transport, they would calculate the journey time to review if they could meet the transport request and if they had staff available to do this. Information was shared within a secure mobile messaging service for staff to ask who was available to commit to the journey. Commissioners told us once the transport request had been agreed the service had a two-hour time slot to get to location. Premier Rescue Ambulance Service did not always meet this timeframe.

Meeting people's individual needs

The service took account of patients' individual needs and preferences based on those who met their criteria.

Requires improvement

Patient transport services

Transport services were planned, delivered and coordinated to take account of patient's needs. We saw all mental health patients were collected in vehicles which were unmarked and had blacked out windows so were not identifiable as ambulances. This was to maintain patients' privacy and dignity.

Managers told us they had a criteria for the patients they were able to transport but this was not written down. They took low risk patients. For example, patients who were mobile, non-infectious patients and those who didn't need oxygen therapy. They did not have access to a vehicle to transport patients who need a stretcher.

A mental health professional told us they were able to request the gender of the care assistant needed to meet the needs of patients. They told us they have had transfers where they needed a female care assistant and this service was able to support this.

Staff had received training in the prevention and management of violence and aggression to meet the needs of their patients.

Staff had access to a telephone interpreting system to support patients whose first language was not English. Managers told us they had not needed to use this service. Managers also told us they had a diverse staff group with some of the staff able to speak other languages. Staff were able to access applications on their mobile phones to help translate if needed. There were no communication aids provided by the service to support staff, for example pictorial cards.

The service was told about patients who had specific needs as part of the booking process and therefore able to decide if they could meet their needs.

A mental health professional told us they were able to travel with the crew in the vehicle if required to meet the needs of the patient being transferred.

Access and flow

People could mostly access the service when they needed it and received the right care mostly in a timely way.

Patients accessed care and treatment in a timely way. The service provided a 24-hour, seven-days a week transport service. These included detained patients and other patients who needed transport between other locations, for example, between hospitals.

Transport requests were dealt with by the managers in the week and out of hours/weekend by the on-call manager. They liaised with the provider requesting the transfer to if they could meet the request.

The commissioners from the local mental health NHS trust told us they had a two-hour timeframe for the transfer request once it had been accepted. They said Premier Rescue Ambulance service did not always meet this time frame which impacted on their service provision.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients were not routinely told they could make a complaint or comment about the service mostly due to their medical condition. We did see leaflets in the vehicles on how patients could complain and provide feedback about the service. In some instances, this may not be appropriate due to the nature of the mental health conditions being supported.

The complaints policy did not go into detail about the procedure for patients, their relatives/carers to follow or what to do if they were not happy with the first outcome of their complaint. There was also no access to an independent review of their complaints.

The providers website did not include any details on how to make a complaint for provide feedback about the service.

The commissioners from the local NHS mental health trust told us they felt the service was very responsive to complaints and they were happy with the outcome from their investigations.

We reviewed two complaints relating to staff behaviour. Both complaints were responded to within two days with a letter explaining that the provider would investigate and

provide a full response. A formal outcome letter was seen in both cases. However, the processes of investigation did not have a fully recorded audit path of how actions were agreed and taken.

The service kept a log of all complaints as part of their monitoring.

Are patient transport services well-led?

Requires improvement

We rated well led as **requires improvement.**

Leadership

Leaders mostly had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had most of the skills, experience they needed to manage the service. The registered manager and nominated individual were both directors for the service. The leadership team was made up of three people. The registered manager was a registered mental nurse with child and adolescent mental health experience. The nominated individual who managed the logistical and vehicles also had mental health experience and would at times undertake transfers with other staff A new member of staff had recently joined the leadership team. They were originally working for the service as part of the transport team. They were a dual registered nurse (registered general nurse and mental health nurse), with many years' experience of working in mental health. They were also a trained to provide training to other staff and they were promoted to provide the service with ongoing training for their staff, supervisions and appraisals. They were also able to provide advice and guidance to the other managers and staff about mental health.

The nominated individual was on call out of hours and was available to staff and other providers for advice and support and to arrange any transfer requests.

Staff told us the managers were visible and they were able to contact them at any time for advice and support.

The services Statement of Purpose did not meet the requirements of the Health and Social Care Act as it lacked detail. For example, it did not mention their regulated activity (this is the activity for which they were registered to provide under the Health and Social Care Act). Following our inspection, the registered manager sent CQC an updated version including the required information.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. But this was not being monitored.

The provider had a clear vision, and this was; to meet national quality standards and clinical requirements, provide the right service for the community and provide a highly responsive service for the users.

The values of the business had not changed since they started and were accountability, integrity, respect, team spirit and transparency. Progress of their priorities and strategy was not always recorded. However, the managers were able to tell us, they had seen an increase in the number of transports in 2019 since they had started a monthly log. They also employed another member of the management team to address shortfalls in training, supervisions and appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The managers told us they felt the culture was about team spirt, valuing what they do, being caring and this was more than a job, it was contributing to the patients recovery. The staff confirmed this. Staff we spoke with felt supported, respected, valued and enjoyed working for the service. They could also approach the managers with any concerns they might have.

Staff had access to a whistle blowing policy devised by the provider. This provided staff with guidance on how to raise issues with the company if thy felt they could not approach a manager directly.

Requires improvement

Patient transport services

The commissioners from the local mental health NHS trust told us they felt the managers were responsive and wanted to address any concerns especially when dealing with complaints about Premier Rescue Ambulance Service.

Governance

Leaders did not always operate effective governance processes to monitor service provision. Staff were offered regular opportunities to meet as a group to discuss and learn from the performance of the service. Staff at all levels were clear about their roles and accountabilities.

The service had some processes and systems to support the delivery of the strategy and good quality, sustainable services, but they were not regularly reviewed and improved. They also did not have a formal system or process in place to regularly manage the governance of the service.

The managers had several monitoring tools they were using, for example the monthly transport logs. But these were not being assessed or brought together to demonstrate if the service they were providing was safe and responsive. However, these had indicated an increase in their workload in the year 2019.

Monitoring of incidents was not in place. Managers told us they reviewed all incident forms to see if there was any learning that needed to be shared with all staff. However, this was not recorded. Staff had recently started to record the use of restraint on their incident forms, but these had also not been audited to help demonstrate the use of restraint was the correct course of action and for the minimal time.

Recruitment files were orderly and available for each staff member; however, they were not fully completed to ensure patients were safe. We reviewed four staff files, there were references missing for all files seen, there were no signed contract and job descriptions and no record of the interview process. There were cases were areas of the application form and police check had not been risk assessed and an action plan completed to ensure patient safety. There was no audit or review of these files to make sure they met the regulations. Senior managers told us they planned to audit staff files so shortfalls could be addressed.

We reviewed three staff meeting minutes. They were not well attended. Agenda items were discussed and minutes recorded. Topics included the need for relevant information about patients to be passed to the team and discussions about culture and staff behaviours. Staff told us they were not always paid to attend these meetings. Managers told us this was something they were looking to review.

We reviewed very limited minutes of a board meeting, the agenda items were recorded and a discussion about the need for staff appraisals.

We found some of their policies and procedures did not have review dates, for example, whistle blowing policy. The managers told us they were reviewing all polices and adding review dates where there did not have one.

Management of risks, issues and performance

Leaders did not use systems to manage performance effectively. They did not document how they identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had no processes to manage current and future performance. Key performance data was not always collected or formally reviewed, for example, if they met the local mental health NHS trust of two hours when agreeing to the transport request.

The managers had not devise their own documented risk register. However, they had devised an action plan to address risks but there was no documented recording how they had decided these were risks to their service. Each risk had been assessed as red, amber or green and actions were provided of the actions they needed to take. For example, equipment replacement was rated a red and cleanliness of their vehicles was rated as green. Managers were also able to verbally detail each of their risks and the actions they had to minimise them.

The service had a business continuity plan to assist all staff in managing an emergency. For example, severe weather and fire. There was no start date on this policy or evidence it had been reviewed an updated as required.

Information management

The service collected information about service delivery. This information was securely stored.

Patient transport services

However, staff did not use this to understand performance, make decisions and improvements. Staff were aware of what needed to be notified to external organisations as required.

The service was collecting data but not using this to measure the quality of the service. For example, they were not monitoring if they met the two-hour timeframe from when they agreed to the transport request and arrival at the location. This timeframe was part of the agreement set by the local mental health NHS trust. Commissioners told us that Premier Rescue Ambulance Service did not always meet this timeframe.

The service had started a monthly log of all transport requests, but this data was not used to help understand their performance. However, managers were able to tell us this data had shown the amount of transfer they had completed in 2019 were almost double compared to 2018.

The provider undertook limited audits so they could not be used to help them identify the strengths and weaknesses of the service.

Managers had access to IT systems, and these were password protected. Staff were able to store patient records securely during transfer in the vehicle away from the patient.

Managers were aware of when they needed to notify external organisations of incidents. For example, to CQC for a death of a patient during transfer.

Public and staff engagement

Leaders engaged with local organisations to plan and manage services. Staff were not always included in the processes. They collaborated with partner organisations to help improve services for patients.

Senior managers told us it was not always easy to engage with patients who used their service due to their medical conditions.

Staff gave out "Tell us what you think" forms for feedback about the service. The client group was not always able to provide feedback, so response had been limited and no recent forms had been received. However, letters of gratitude and thanks were seen.

Staff meetings took place at regular times but from the minutes we saw these were not well attended. Staff often had other roles with other organisations so this may well be the reason why they did not attend. We did not see any other formal system for staff to engage with the service and provide them with ideas and feedback.

We saw evidence of one session of a debrief for several members of staff following an incident. Managers told us they wanted to continue with debrief sessions on a more frequent basis.

Commissioners from the local mental health NHS trust told us they shared their feedback with the service frequently both positive and negative.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services.

Managers told us they were looking to improve and make sure their business was sustainable. They had recently upgraded their two vehicles to improve the transfer for patients and staff. They were also looking to obtain contracts with NHS and other providers to help maintain the sustainability of their service.

With the addition of a new member of staff to the management team they are looking to improve how they support staff and their wellbeing. For example, by devising a regular supervision and appraisals programme and ongoing in-house training based on the needs of their service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- As part of their recruitment process, they must include how they obtain information about staff conduct in previous roles to include working with vulnerable adults and children. Use the interview process to determine if the applicant is suitable for the role. Maintain records of their decision. Staff with criminal convictions were not risk assessed to make sure they were suitable to work with vulnerable patients. Records need to be maintained of these decisions.
- Ensure that mechanisms are in place to provide all staff at every level with an appraisal and regular supervision.
- There were no records of patients risks and actions to minimise these and no information about patients medical conditions for staff to refer to.
- There were no systems to assess and monitor the service provision to include the use of audits to help improve the quality and safety. Incidents and the use of restraint were not audited and actions or learning recorded.

Action the provider SHOULD take to improve

- To add all training to the staff training matrix to show who has completed what training and to help with monitoring when training is due.
- Train a member of staff to level 4 safeguarding so they have knowledge and skills to support staff.
- To review the cleaning solution used to make sure they meet best practice guidance for cleaning of any bodily fluids.
- More details need to be included in the travel records about patient infection control risk.
- Records should be maintained of the daily checks undertaken by staff to make sure the vehicles are safe for use.
- Maintain records of any learning shared with staff from incidents.
- To undertake checks on staff driving abilities to make sure they are safe.
- When managers join journeys with staff to maintain records of this as part of the staff ongoing assessment of their competency to meet the requirements of their role.
- Provide evidence staff are competent to meet their roles at interview, end of induction and ongoing.
- To provide evidence that policies and procedures are devised/reviewed using the latest and best practice guidance.
- Review the structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.
- Document their criteria for which patients they will and won't transfer.
- Review their complaints process to add in the process for what happens if the complainant is unhappy with the first outcome. Look to add in an independent review of their complaints.
- Provide staff with access to pictorial cards to aid communication for patients who are not able to verbally communicate.
- Devise a written risk register.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no evidence of monitoring and assessing the quality of the service. Records of patients risks, and actions taken to minimise these were not kept or information about their medical condition. Incidents were not being reviewed and any actions needed recorded. There was also no recorded evidence of shared learning.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff employed by Premier Rescue Ambulance Service Limited had yet to receive an annual appraisal or direct supervision.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Staff with evidence of criminal convictions were not risk assessed before working with vulnerable people. There was no evidence to demonstrate for proposed staff that;

This section is primarily information for the provider

Requirement notices

satisfactory evidence of conduct in previous employment concerned with the provision of health and social care or children and vulnerable adults had been obtained. Or whey they had left this employment.

Interview process to demonstrate applicants suitability for the role.